Cross System Collaboration Addressing Social Determinants of Health

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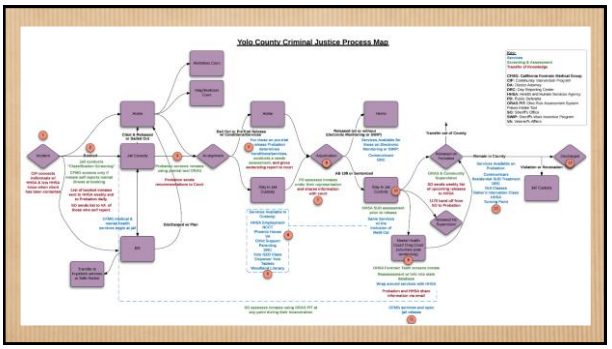
Yolo County

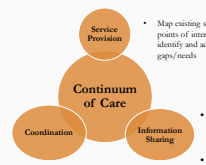
County Strategic Plan 2016-2019

- **Strategic Plan Focus Area:** "Develop coordinated continuum of care ranging from prevention through intensive services"
- **Vision:**
  - Improved **service provision** that assists in preventing adults from entering or penetrating deeper into the criminal justice system.
  - Increased **information sharing** and **coordination** among law and justice departments and service/community providers to improve services, enhance outcomes and reduce duplication of effort

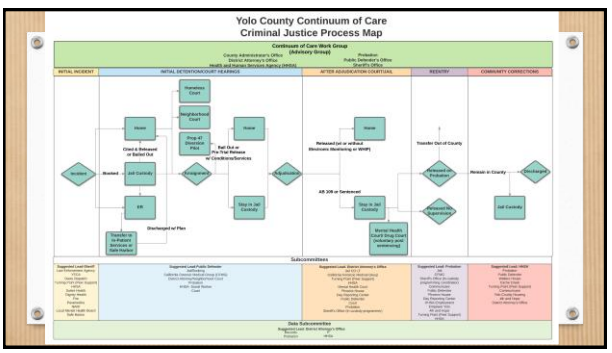


Continuum of Care Work Group

- **Milestones**
- **Creation of Subcommittees**
  - More detailed analysis by larger cross section of involved stakeholders
  - Pool resources and serve as the driving force to implement action items



- Map existing services and points of intercepts to identify and address gaps/needs
- Develop system to share data, track individuals, and evaluate program outcomes
- Criminal Justice Dashboard
- Establish Subcommittees



Informing Recommendations and Implementation Plans

1	2	3	4
Reduce	**Shorten**	**Increase**	**Lower**
The number of people with MI booked Into jail	The average length of stay in jails	The percentage of connection to care	Rates of recidivism
• Police-Mental Health Collaboration programs • CIT training • Co-responder model • Crisis diversion centers • Policing of quality of life offenses	• Routine screening and assessment for mental health and SUDs in jail • Pretrial mental health diversion • Pretrial risk screening, release, and supervision • Bail policy reform	• Expand community-based treatment & housing options • Streamline access to services • Leverage Medicaid and other federal, state, and local resources	• Apply Risk-Need-Responsivity principle • Use evidence-based practices • Apply the Behavioral Health Framework • Specialized Probation • Ongoing program evaluation

Intercept 1
Community Services/Law Enforcement

- Mental Health First Aid
- Crisis Intervention Training
  - MHSA funded
  - Offered to all first responders
  - Offered to all dispatch
  - Offered to all Law Enforcement
- Mental Health Urgent Care
  - MHSA, Hospital, Maddy
- First Responders Initiative
  - MHSA Innovation
- Community Intervention Program
  - SB82

Intercept 2
Initial Detention/Initial Court Hearing

- Gaps
  - Housing, transportation
  - Limited in person psychiatrists
  - Programs for women with trauma
  - Lack of baseline data
  - Ability to share information across systems in a timely fashion
- Solutions
  - Expand Prop 47 pilot
  - Expand pretrial
  - Expand misdemeanor IST response
  - Universal intake screening
  - Communication from LEA to DA prior to court if MH issues suspected

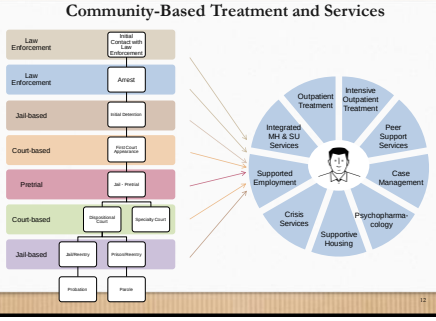
Intercept 3
Jail/Courts

- California Forensic Medical Group
- In Custody Programming
- Day Reporting Center
- Mental Health Court
- Assisted Outpatient Treatment
- Addiction Intervention Court
- Neighborhood Court
- Homeless Neighborhood Court

Intercept 4
Reentry

- Gaps
  - Electronic monitoring underused
  - Discharge planner
  - Straight sentence get no release planning
  - Not enough Housing options
  - Engaging SMI, homeless, post release
- Potential Solutions
  - Supported living housing
  - Training around conservatorship requirements
  - Re-entry Coordinator
    - Social worker or probation officer
    - Mental health staff to connect before release

Connecting People to Community-Based Treatment and Services



Therapeutic Continuum of Care

Client and family members are engaged at **every** level, in **every** decision.

Depending on the severity of mental health needs and/or substance abuse issues, an appropriate level of care will be determined by the care team along with **client and their family**.

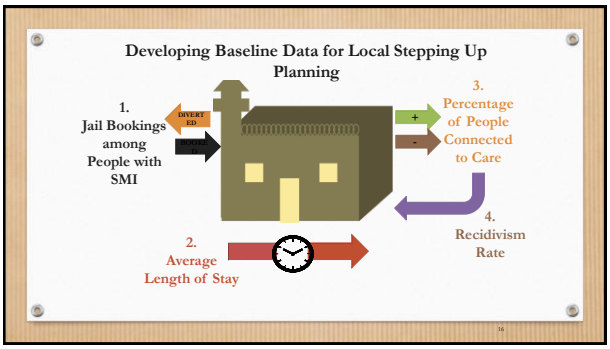
	Prevention	Mild to Moderate	Serious Conditions
Mental Health Services	• Urban and rural resilience programs • Mental health first aid • Crisis intervention training • Self-help/assist	• Primary Care Providers • Beacon Providers • Brief, solution focused treatment (generally 10 sessions)	• Psychiatric oversight and treatment • Turning Point Community Programs • Safe Harbor/Crisis Residential • Psychiatric Health Facility • Institutions for Mental Disease • Inpatient Psychiatric Hospitalization
Substance Use Services	• Screening, brief intervention, and referral to treatment in primary care setting • Friday Night Live	• Outpatient substance use treatment of 4 to 9 months • Brief intervention (6 to 8 visits) • Smoke less • Adolescent youth treatment	• Intensive outpatient program • Residential treatment of 3 to 6 months • Medication Assisted Treatment • Inpatient/Outpatient Detoxification
Primary Care Services	• Physical examination • Health screening • Health education • Lab work • Immunization/flu shots	• Chronic disease management • Health education • Regular appointments • Dental care	• Referrals to specialty care • HIV case management • Skilled Nursing Facility • Hospitalization
Service Linkages	• Community recovery support systems • Faith based organizations	• Vocational/educational agency services and supports • Housing opportunities • Food • Transportation	• Sort Term Emergency Aid Committee (STEAC) • General Assistance • Sacramento Metropolitan Advocates Resource Team-Yolo (SMART-Y)
Homeless Services	• Eviction prevention • Landlord mediation • Arrear assistance	• Street outreach • Assessment • Linkage to community-based resources • Emergency shelter • Interim bridge housing	• Intensive case management • Permanent supportive housing • Housing navigation and placement assistance • Peer support • Employment assistance

Intercept 5
Community Corrections

- Gaps
  - No linkage past transitional housing
  - Housing, transportation
  - Ability to track among providers
  - Limited navigation
  - 42CFR
- Potential solutions
  - Employment linkages
  - Transitional housing, board & care etc
  - Social/peer navigators
  - Develop waiver for sharing information
  - Shared platform across systems

Intercept 6
Data Sharing

- Court, Sheriff, District Attorney, Probation, Dispatch
- Treatment providers- County, non-profits, Jail/JDF medical, hospitals, healthplan
- Out of county LEAs



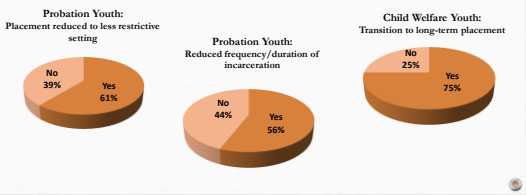
Funding/New Initiatives

- Homeless funding
  - SAMHSA
  - Partnership Healthplan
  - IGT
  - MHSA
  - CalWorks
  - HDAP
- Substance Use Disorder Funding
  - Drug Medi-Cal Waiver
  - CCP MOU
  - SAMHSA
  - Prop 47
  - Naloxene
  - Hub & Spoke

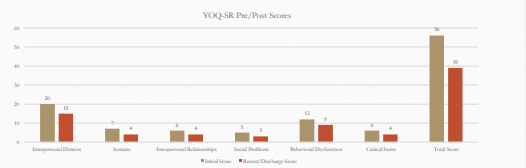
Juvenile Justice System

- Services
- Functional Family Therapy
- Trauma Focused CBT
- Thinking 4 Change
- CSEC
- Wrap/FSP
- Funding
- MIOCR
- EPSDT
- MHBG/SAPT
- Probation

MIOCR Outcomes – Youth Placement Stabilization



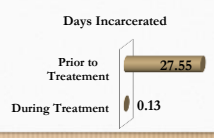
MIOCR Outcomes Youth Outcome Questionnaire

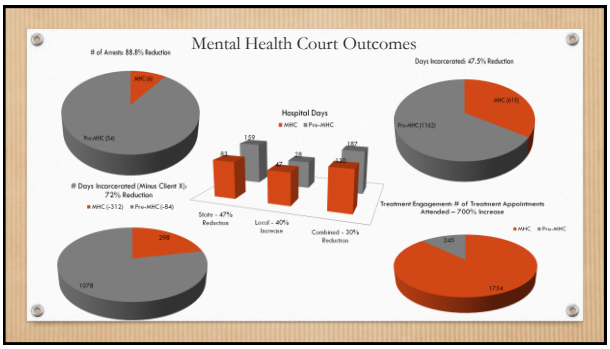


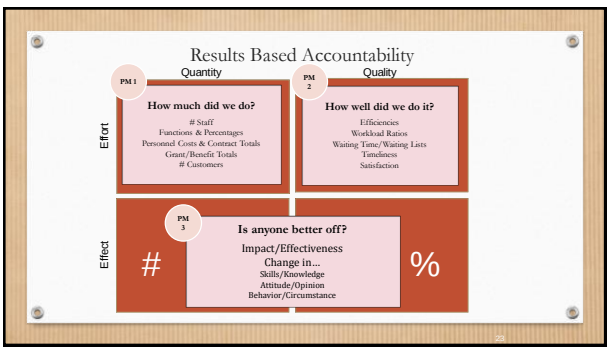
Outcomes- Incarceration

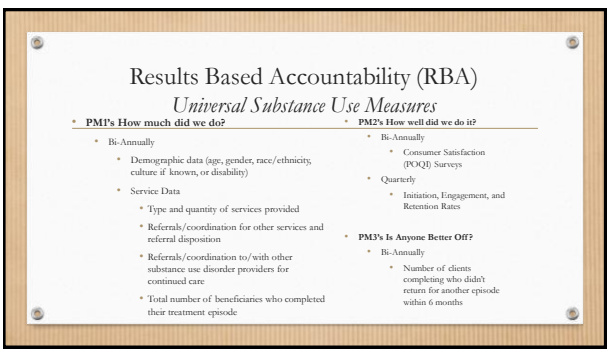
(November 2016 – April 2017)

- Outpatient services began tracking incarceration data in November 2016
- Average days incarcerated prior to treatment was 27.55 compared to 0.13 days during treatment
- 99.95% reduction in days incarcerated
- Provider will continue to track post graduation to determine whether gains are sustained




Mental Health Court Outcomes
# of Arrests: 88.8% Reduction
MHC (8)
Pre-MHC (54)
Days Incarcerated: 47.5% Reduction
MHC (610)
Pre-MHC (1162)
Hospital Days
MHC
Pre-MHC
159
51
47
28
187
130
State - 47% Reduction
Local - 40% Increase
Combined - 30% Reduction
Days Incarcerated (Minus Client X): 72% Reduction
MHC (-312)
Pre-MHC (-84)
298
1078
Treatment Engagement: # of Treatment Appointments Attended – 700% Increase
MHC
Pre-MHC
245
1754


Results Based Accountability
Quantity
Quality
PM 1
How much did we do?
Staff
Functions & Percentages
Personnel Costs & Contract Totals
Grant/Benefit Totals
Customers
PM 2
How well did we do it?
Efficiencies
Workload Ratios
Waiting Time/Waiting Lists
Timeliness
Satisfaction
Effort
Effect
PM 3
Is anyone better off?
Impact/Effectiveness
Change in...
Skills/Knowledge
Attitude/Opinion
Behavior/Circumstance
#
%


Results Based Accountability (RBA)
Universal Substance Use Measures
PM1's How much did we do?
Bi-Annually
Demographic data (age, gender, race/ethnicity, culture if known, or disability)
Service Data
Type and quantity of services provided
Referrals/coordination for other services and referral disposition
Referrals/coordination to/with other substance use disorder providers for continued care
Total number of beneficiaries who completed their treatment episode
PM2's How well did we do it?
Bi-Annually
Consumer Satisfaction (POQI) Surveys
Quarterly
Initiation, Engagement, and Retention Rates
PM3's Is Anyone Better Off?
Bi-Annually
Number of clients completing who didn't return for another episode within 6 months

Example: Bridge to Housing

Program Name	Bridge to Housing
Program Purpose	Permanently house individuals living on the river bank in West Sacramento and increase benefits and the level of their income
PM1: How much did we do?	
Quantity	# of people who participated in the program
PM2: How well did we do it?	
Quality	% and # of participants that remained engaged at the end of the program
PM3: Is anyone better off?	
Outcome	• % and # of participants who completed the program and secured permanent housing • % and # of participants with increased benefits (CalFresh and Health Insurance) • % and # of participants that increased their income

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